Commonwealth of Massachusetts

Executive Office of Health and Human Services

Special Commission on Graduate Medical Education

May 13, 2013

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Agenda

- Approval of minutes
- Financial analysis
- National policy context
- Framework for Commission report

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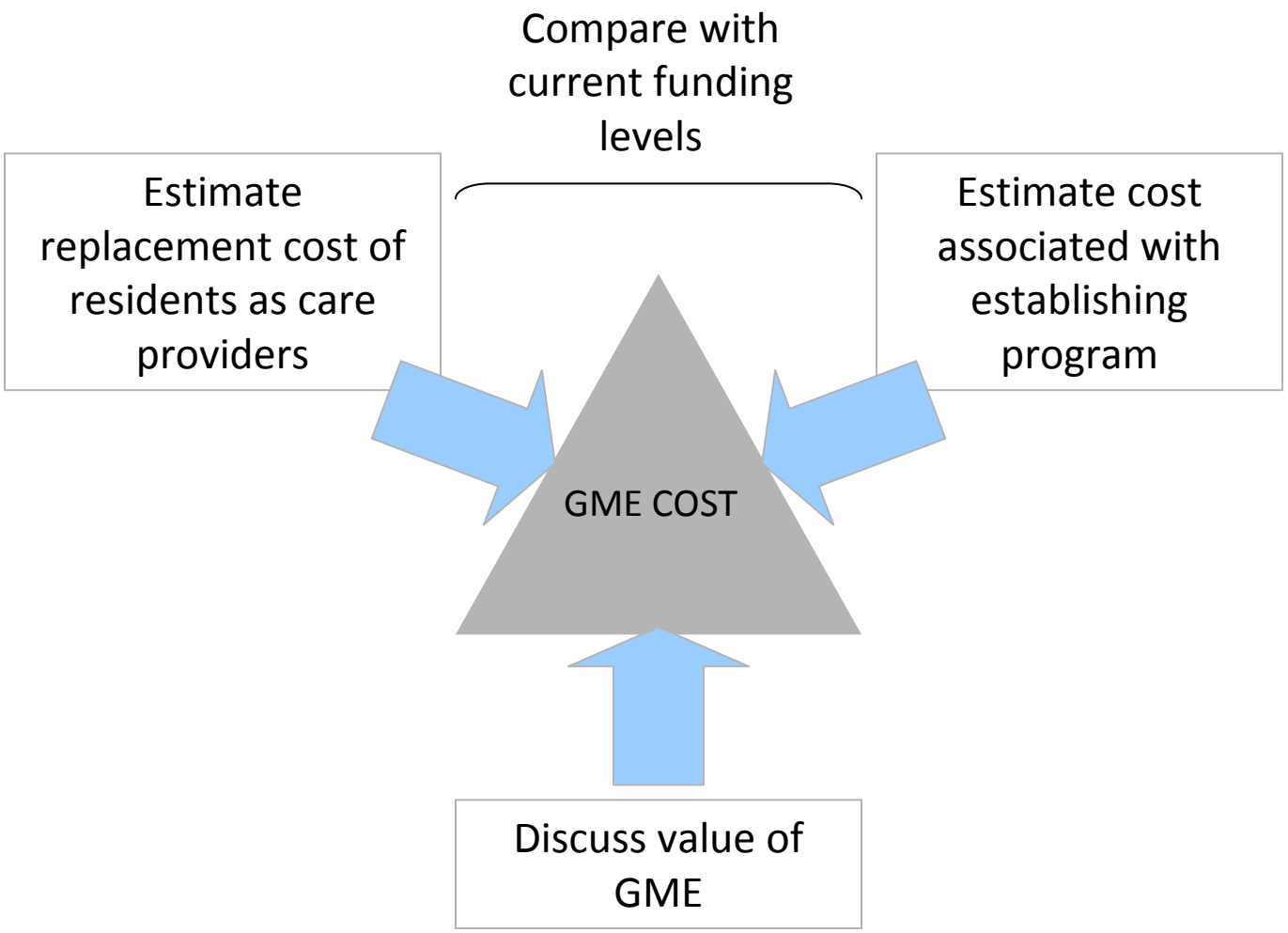
Financial analysis: multi-pronged approach to understanding costs



Approach 1: Estimate replacement cost of residents as care providers

Approach:

- What is the cost associated with patient care activities provided by residents?

Caveats:

- Represents only a narrow view of role of GME programs (i.e., in delivery of care) without regard to their role in education, innovation, workforce, etc.

Key assumptions:

- Hours of patient care provided by residents
- Composition of replacement workforce
- Estimated salaries for replacement workforce

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Step 1: Estimate hours worked by residents per year

	Number in Massachusetts	Estimated Hours Worked per Year
Interns	1,042	2.9 M
Residents, PGY2-8	4,372	10.5 M
Total	5,414	12.1 M

Assumptions:

Interns work 46 weeks per year at 60 hours per week

Residents work 40 weeks per year at 60 hours per week

Sources: ACGME Data Resource Book for the 2011-2012 Academic Year and National Resident Matching Program, 2012 NRMP Main Residency Match: Match Rates by Specialty and State (April 2012). Available at: http://www.nrmp.org/data/resultsbystate2012.pdf

Step 2: Estimate cost of NPs and PAs in Massachusetts, and hours worked

	Avg Annual Salary	Salary plus 25% fringe	Hours per week	Weeks per year
NP	$97K	$122K	40	48
PA	$99K	$123K	40	48

Source of salary information: 2012 Medical Office Practice Compensation Survey by Gallagher Surveys

Step 3. Estimate number of NP and PAs needed to replace residents

	Total Hours worked	Number of NP-PA replacements needed	Cost of NP-PA replacements
Resident hours only	10.5 M	5,465	$671 M
Resident hours plus 50% of intern hours	11.9 M	6,214	$763 M

Assumptions

Assumes that positions can be filled by NPs or PAs (may not be true for all positions)

Assumes that there are adequate numbers of NPs and PAs available for hire

Assumes 50:50 mix of NP and PA

Approach 2: Estimate of cost of starting a GME program

Approach:

- What is the cost associated with standing up a GME program?

Caveats:

- Based on current model of teaching/training
- Does not capture all costs (such as licenses, accreditation fees, malpractice, food, travel, educational allowances, etc.)

Key assumptions:

- Resident salaries
- Estimates of teaching faculty to resident ratios
- Faculty salaries
- Program director and administrator FTE, salary

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Step 1: Estimate direct resident costs by specialty

Direct costs

- Salary: assumed average of $55,000 for PGY1-3, average of $59,000 for PGY4-7
  - Based on 75th percentile of 2012-2013 salaries reported by AAMC Survey of Annual Resident/Fellow Stipends. 75th percentile was selected based on review of salaries listed for selected 2011-2012 programs in the state
- Fringe: assumed 25% fringe

Distribution of residents by specialty

- Obtained from AAMC 2011 data
  - Some categories were “collapsed” to facilitate analysis

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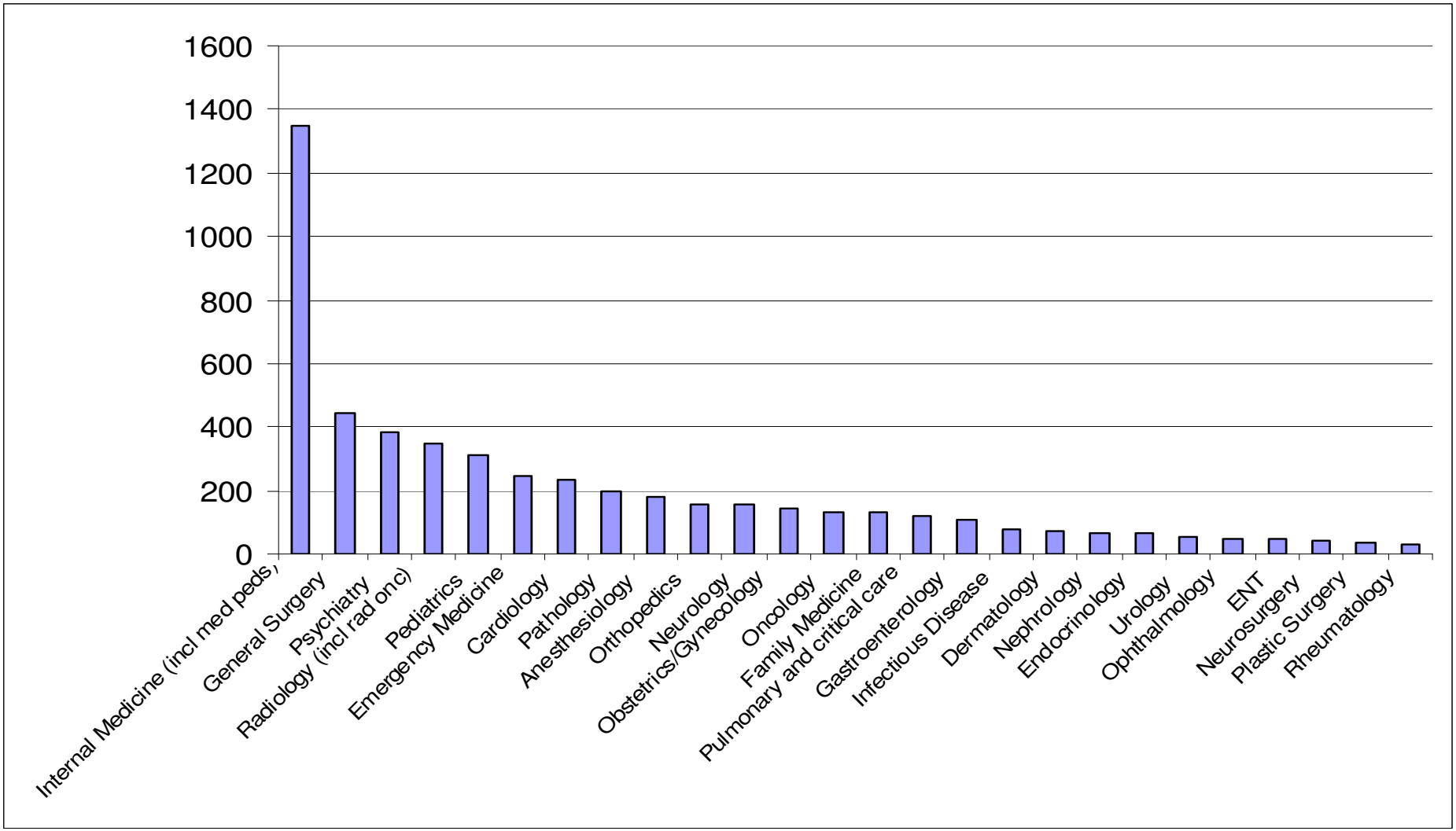
Distribution of residents by specialty (MA, 2011)



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Step 2: Estimate teaching costs by specialty

Teaching costs

- Assumed a faculty to resident ratio of 1:12, 1:10 or 1:6 based on expected teaching intensity

  1: 12 includes anesthesia, surgery, and surgical subspecialties

  1:10 includes medical subspecialties

  1:6 includes medicine, psychiatry, pediatrics

- Faculty salaries based on mean medical school faculty salaries by specialty at assistant professor level for northeast region, 2010-2011, from AAMC

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Step 3: Estimate program costs by specialty

Program Director

- Assumed one program director per program in state
- FTE for program director based on RRC requirements, where available, and average program size (range from 0.5 to 2.5)
- Program director salary based on mean medical school faculty salaries by specialty at assistant professor level for northeast region, 2010-2011, from AAMC

Administrative costs

- Assumed one administrative position per program
- Estimated $80,000 per year in administrative costs

Did not include a number of other costs such as educational allowances, travel, facility costs, malpractice, and accreditation

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Results

	Salary plus fringe	Teaching costs	Program costs	Total
Per resident cost (range)	$68,750-$73,750	$20,463-$60,760	$4,672-$26,353	**$99,388-$152,809**
Per resident cost (weighted avg)	$69,881	$35,270	$8,786	**$113,937**

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Comparison to funding levels

	Total	Per resident
Estimated replacement cost	$671- $763 M	$124-141K
Estimated cost of establishing a program	$590 M	$114K ($99-153K)
Total Medicare funding to Massachusetts for GME	$546 M	$101K

*Estimates of cost do not take into consideration clinical revenue generated by residents/fellows

* Analysis does not address any “shifting” of uncompensated costs

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Other studies

- Other estimates:
  - $100,000 (AAMC)
  - $130,000 (Steinmann 2011)
  - $130,000 – $200,000 (University of California 2011)
- 1999 analysis of anesthesia program at Univ. of Texas found instructional costs of $75,070 per resident; the estimated replacement value of the teaching and clinical services provided by residents was $103,436 per resident per year (Franzini, Anesthesiology 1999).
- 2001 analysis of GME costs in Minnesota found mean direct costs of $130,843 (52% faculty cost, 26% resident cost, 22% administration) (Blewett, Academic Medicine 2001)
- 2003 Univ. of Washington Family Medicine Network study estimated revenue per resident of $79,959 from federal GME payment and $115,576 in mean net patient service revenue, compared to expenses of $274,239 (Pauwels, Family Medicine 2006)
- “Hidden costs of residency” estimated at $4439 per resident (range $1500 to $9417) (Kelly, J. Grad. Med. Ed., 2012)

Understanding the value of GME: additional considerations

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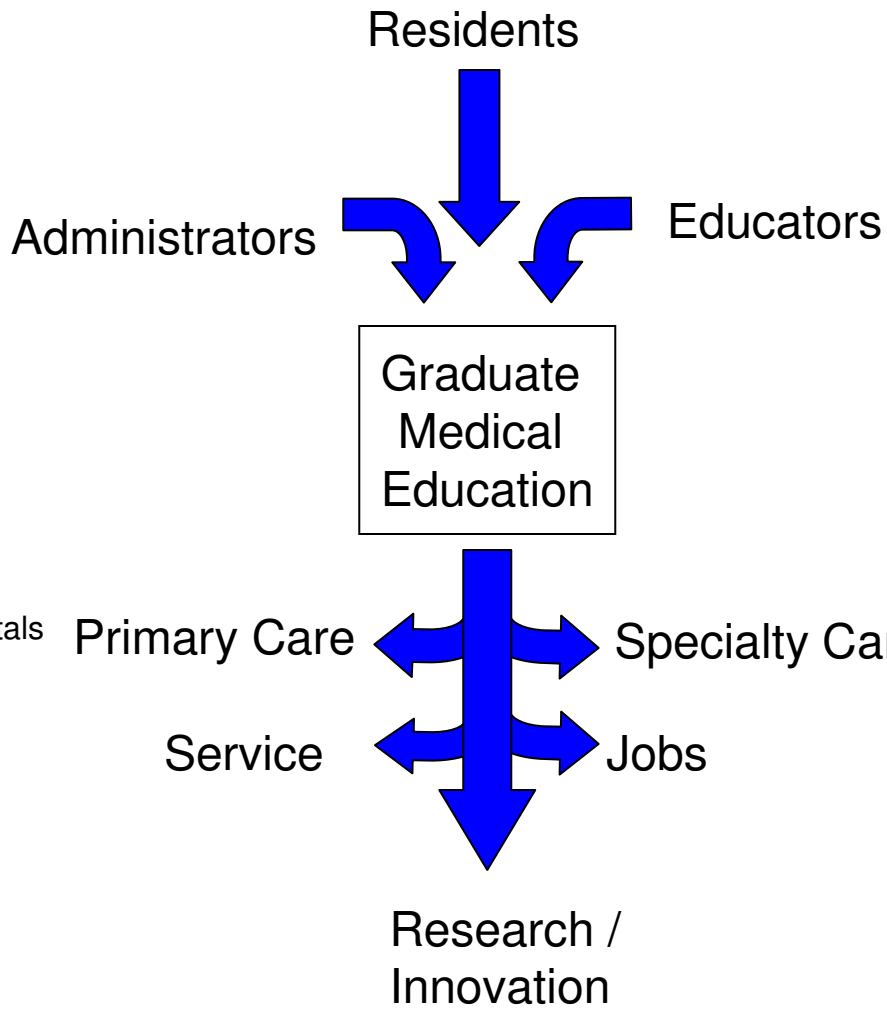
- Previous approach looks at costs of GME, but does not address value
- Many types of value or potential value, such as:
  - Role of academic medical centers in providing specialty care
  - Role of academic medical centers in research/innovation
  - Role of GME in generating future workforce
    - Massachusetts retention rate 44.6% (AAMC 2011 Physician Workforce Data Book)
  - Indirect economic benefits to the local economy
  - Care for underserved patients
  - Faculty recruitment
- These benefits can be difficult to quantify

Understanding the value of GME: additional considerations



- >50% of safety net hospitals are staffed by residents
- > 75% of VA Medical Centers are staffed by residents
- >95% of burn centers are staffed by residents
- Research and education attract grants that generate local employment opportunities

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Discussion of financial analysis

- What is missing?
  - Other reports, data sources
  - Other categories of “inputs”
  - Other approaches to understanding “value”

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Federal GME context

- 6/2010 – MedPAC recommended decreasing IME payment from 5.5% to 2.5%, using savings to create performance-based educational incentives
- 12/2010 – Simpson-Bowles recommended decreasing IME payment from 5.5% to 2.5%, funnel savings into Medicare
- 6/2012 - Institute of Medicine commissioned to review GME with an emphasis on increasing the capacity of the clinical workforce, reviewing current financing and governance
- Sequestration – As of 3/1/2013, Medicare has been subject to 2% funding cut
    - 2% at FY2010 funding levels = $10.9 million

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Federal GME legislation

- HR 1201/ S 577
  - Sponsored by Reps Schock (R-IL) and Schwartz (D-PA), Sens Nelson (D-FL) and Schumer (D-NY)
  - Would increase GME funding over 5 years to support 15,000 physicians at estimated cost of ~$1 billion
- HR 487
  - Sponsored by Rep Rodgers (R-WA) and Thompson (D-CA)
  - Would authorize HHS via CMS Title XVIII to conduct a 5-year GME innovation pilot for primary care funding

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Future prospects for GME funding

Budgetary Announcements

- HHS has not released information regarding exactly how sequestration cuts will effect GME
- President's budget for FY2014 proposed 10% cut to IME funding (estimated savings of $10 billion over 10 years)
- Institute of Medicine report due 12/2013
    - Legislative action may be delayed pending report findings
- Debt reduction remains a significant barrier to increasing GME funded slots

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Proposed report outline

- **Executive Summary**
- **Overview of Commission**
  - Statutory Charge
  - Commission Members
  - Organization/schedule of work
- **Overview of Graduate Medical Education in Massachusetts and the United States**
  - Definition of graduate medical education
  - Number of slots and programs; distribution by specialty
  - Overview of funding sources (DGME and IME payments through the Medicare Program, THGME, CHGME, Veterans' Affairs)
  - Overview of primary care loan forgiveness and related programs
- **Relationship of Graduate Medical Education to the state's physician workforce and emerging models of delivery of care**
  - Review estimates of workforce needs
  - Discussion about impact of emerging models of medical care on the physician workforce (summary of presentation by RAND Corporation)
- **Financial analysis of costs of GME**
  - Estimating costs of replacing residents as care providers
  - Estimating costs of establishing a GME program
  - Comparison to current funding level
  - Discussion of broader value of GME
- **Approaches taken by other states.**
  - Overview of relevant AAMC survey findings
  - Interviews from 4 states – MN, NY, OK, TX
- **Recommendations**

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Recommendations

- Should stem from the goals for GME identified by the Commission.
- Would like to have initial discussion of goals in order to get us to recommendations

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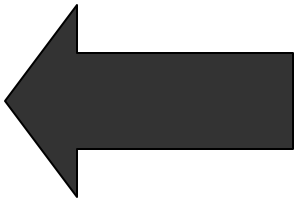
Framework for discussing recommendations

What do we want to achieve?

Enhance workforce supply
-Primary care?
-Specialties?
-Geographic distribution?
-State or national needs?
-Overall levels?

Enhance workforce skills/capabilities
-Team-based care?
-Ambulatory care?
-IT?

Research/innovation
-In basic science?
-In clinical practice?
-In medical education?



How will we get there?

Funding
-How much?
-To whom?
-For what?

Governance
-New structure?
-Connect with existing efforts (health care workforce center and advisory council, health planning)

Outreach and Education
-Communications and other public initiatives

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Work Plan

February 24

- Areas of focus:
    - Overview of the Special Commission on Graduate Medical Education
    - Overview of Graduate Medical Education, including statistics and information about funding sources
    - Discussion of work plan

March 29

- Briefing Book distributed to Commission members
- Areas of focus:
    - The relationship of graduate medical education to the state's physician workforce and emerging models of delivery of care
    - Approaches taken by other states regarding GME funding (results of state interviews and research)
    - Discussion and approval of work plan

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Work Plan

May 13:

- Areas of focus
  - National policy context
  - Approaches to understanding the adequacy of revenues for GME and measuring the impact of GME funding
  - Discussion of goals for GME in the Commonwealth

June 18:

- Areas of focus
  - State primary care workforce programs
  - Other topics
  - Development of draft recommendations

July 11:

- Areas of focus
  - Finalizing recommendations and report